STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E015	A. BUILDING _____ B. WING _____	C 08/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRISELL MEMORIAL HOSPITAL LTCU	330 S VERMONT PO BOX 268 RANSOM, KS 67572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #77943 and partial extended survey.	F 000		
F 223 SS=G	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: The facility had a census of 30 residents. The sample included 3 residents. Based on observation, interview, and record review the facility failed to provide 1 of 3 residents with a safe envrionment to be free from potential abuse by not immediately investagating Resident #1's accusation of abuse against a staff member, leaving the resident fearful. Findings included: Findings included: - Resident #1's signed physician orders, dated 8/1/14, revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion), worsening expressive aphasia (condition with disordered or absent language function), depression (abnormal emotional state	F 223		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 223	Continued From page 1	F 223		

characterized by exaggerated feelings of sadness, worthlessness and emptiness), macular degeneration (progressive deterioration of the retina), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The quarterly (MDS) Minimum Data set 3.0 assessment, dated 7/29/14, indicated the resident had intact cognition with a (BIMS) Brief Interview for Mental Status score of 13 without any behaviors exhibited, and had impaired vision with use of corrective lenses. The MDS further indicated the resident was independent with all of his/her activities of daily living and had received antianxiety, antidepressant, and diuretic medication.

The 5/15/14 care plan instructed the staff to visit with the resident during personal cares, to assist the resident to find words when needed, and to assist the resident with decision making as needed.

The 7/15/14 physician's progress note indicated the resident wanted to go home, but the resident was not capable to care for him/herself any longer.

The 8/3/14 at 5:00 PM nurse's note revealed the resident was visibly upset regarding the incident which involved inappropriate touching by a staff member that had happened a few nights ago. The note indicated the staff explained to the resident things would be okay and the incident would be discussed with the long term care supervisor on Monday.

Review of the July/August 2014 nursing schedule

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revealed Nurse Aide C worked the following shifts:
- 7/30/14 6:00 PM to 6:00 AM
- 8/2/14 2:00 PM to 10:00 PM
- 8/3/14 6:00 PM to 6:00 AM

The 8/4/14 at 8:00 AM nurse's note indicated the resident continued to be upset regarding the incident. The note indicated the resident stated he/she did not sleep at all the night before. The note revealed the long term care supervisor was not available to discuss the incident and the resident was concerned no one would believe him/her. At 6:30 PM, the note indicated the resident had spoke with the long term care supervisor, was ensured the incident was being handled, and the resident felt a little more at ease.

On 8/5/14 at 1:20 PM, observation revealed the resident lying sideways on his/her bed listening to an audio book. Continued observation revealed the resident independently sat up and engaged in conversation with the surveyor. Observation revealed the resident became tearful, with his/her eyes bright red and filled with tears when he/she discussed the incident of being inappropriately touched by a staff member. The resident stated a male nurse aide had come into his/her room at 4:00 AM, sat down his/her water pitchure and had fondled the resident's chest, and stated "you know you like it". The resident continued to state he/she yelled for the nurse's aide to leave his/her room.

On 8/6/14 at 2:11 PM, observation revealed the resident independently ambulated into the hallway with his/her walker. Continued observation revealed when discussing the previous incident,

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F 223	Continued From page 3	F 223		

the resident's eyes immediately turned red and flooded with tears. The resident became concerned he/she would be in trouble for reporting the incident and was frightful he/she would be shot with a gun by the accused staff.

On 8/5/14 at 11:00 AM, Administrative Nurse F stated he/she had been notified the resident had accused Nurse Aide C inappropriately touched him/her at 4:00 AM when his/her water was passed. Administrative Nurse F further verified Nurse Aide C continued to work the weekend after the resident had reported the incident to the staff and the staff had not notified the administrative staff over the weekend. Administrative Nurse F verified Nurse Aide C was suspended on Monday 8/4/14, pending the outcome of the investigation. Administrative Nurse F further verified on Saturday 8/2/14 and Sunday 8/3/14 the staff had filled out incident reports and placed them in a locked box outside of the quality improvement officer's office. Administrative Nurse F further verified he/she was not aware of the incident until the quality improvement officer notified him/her mid-morning on Monday 8/5/14. Administrative Nurse F verified the only male aide who had worked with the resident was Nurse Aide C, the other employed male aide in the facility, is a friend of the resident and the male agency aide had worked a day shift.

On 8/5/14 at 1:35 PM, Nurse Aide B stated on Saturday 8/2/14, he/she visited with the resident. Nurse Aide B stated the resident had revealed to him/her, a few nights prior, a staff member had come into the resident's room around 4:00 AM, slammed his/her ice water down on the bedside table, and had fondled his/her chest. Nurse Aide

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B verified he/she had filled out an incident report on Saturday on 8/2/14.

On 8/5/14 at 2:25 PM, Administrative Nurse F verified he/she reviewed the facility's video surveillance and revealed Nurse Aide C was in the resident's room at 4:12 AM on 7/31/14 to deliver his/her water pitcher, the video surveillance revealed Nurse Aide C was in the resident's room for 1 minute and 1 second.

On 8/5/14 at 2:40 PM, Nurse E stated the resident notified him/her of the incident on Sunday 8/3/14, and the resident had reenacted the incident to describe what had happened. Nurse E verified the resident was tearful and frightened the accused staff member was going to work Sunday 8/3/14, night. Nurse E stated he/she informed a Medication Aide not to allow Nurse Aide C to work with the resident Sunday night, 8/3/14.

On 8/5/14 at 3:35 PM, Nurse Aide C verified he/she worked in the facility and provided care to the residents on Saturday 8/2/14 and Sunday 8/3/14.

On 8/5/14 a 4:16 PM, Nurse Aide D verified the resident had told him/her on Saturday 8/2/14, about the incident of a staff member touching him/her inappropriately. Nurse Aide D verified he/she filled out an incident report on Saturday 8/2/14 and Sunday 8/3/14. Nurse Aide D stated on Sunday 8/3/14, the resident told hm/her the accused staff (Nurse Aide C) would work that evening and had broke down in tears and had stated he/she wanted the call light close and did not feel safe.

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On 8/5/14 at 4:41 PM, Nurse Aide A stated on Sunday 8/3/14, the resident's call light went off, which was unusual due to the resident was independent with his/her activities of daily living, so the staff went to answer the call light quickly. Nurse Aide A revealed upon entering the resident's room he/she was found to be fearful and requested help to attach his/her call light so he/she could reach it in case the accused staff member (Nurse Aide C) came in his/her room, since Nurse Aide C was working that evening.

On 8/6/14 at 12:15 PM, Administrative Staff G verified Nurse Aide C had continued to work with other resident's in the facility after the resident had made the allegations of him/her being inappropriately touched for 2 days. Administrative Staff G further verified the staff had not notified his/her of the resident's accusations over the weekend and was not made aware until Monday 8/5/14. Administrative Staff G verified Nurse Aide C was not suspended until Monday 8/5/14, pending the outcome of the investigation.

The facility's undated Abuse, Neglect and Exploitation policy indicated all facility employees, family members and volunteers are educated that all alleged or suspected violations involving mistreatment, neglect or abuse are reported immediately to the Administrator. The policy continued to indicate any alleged perpetrator of abuse, neglect, or exploitation, will be immediately suspended from employment and will leave the employment property and not return to the property until the investigation by the facility and law enforcement is complete and the incident is resolved.

The faciitly failed to provide Resident #1 with an

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F 223	Continued From page 6 environment free from abuse.	F 223		
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

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This REQUIREMENT is not met as evidenced by:
The facility had a census of 30 residents. The sample included 3 residents. Based on observation, interview, and record review the facility failed to report immediately to administration, the allegation of abuse reported by Resident #1, and effectively investigate allegations of 1 of 3 residents. This failure placed all residents in immediate jeopardy.

Findings included:

- Resident #1's signed physician orders, dated 8/1/14, revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion), worsening expressive aphasia (condition with disordered or absent language function), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), macular degeneration (progressive deterioration of the retina), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The quarterly (MDS) Minimum Data set 3.0 assessment, dated 7/29/14, indicated the resident had intact cognition with a (BIMS) Brief Interview for Mental Status score of 13 without any behaviors exhibited, and had impaired vision with use of corrective lenses. The MDS further indicated the resident was independent with all of his/her activities of daily living and had received antianxiety, antidepressant, and diuretic

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F 225	Continued From page 8	F 225		

medications.

The 5/15/14 care plan instructed the staff to visit with the resident during personal cares, to assist the resident to find words when needed, and to assist the resident with decision making as needed.

The 7/15/14 physician's progress note indicated the resident wanted to go home, but the resident was not capable to care for him/herself any longer.

The 8/3/14 at 5:00 PM nurse's note revealed the resident was visibly upset regarding the incident, which the resident allegated being inappropriately touched by staff, had happened a few nights ago. The note indicated the staff explained to the resident things would be okay and the incident would be discussed with the long term care supervisor on Monday.

Review of the July/August 2014 nursing schedule revealed Nurse Aide C worked the following shifts:
- 7/30/14 6:00 PM to 6:00 AM
- 8/2/14 2:00 PM to 10:00 PM
- 8/3/14 6:00 PM to 6:00 AM

The 8/4/14 at 8:00 AM nurse's note indicated the resident continued to be upset regarding the incident. The note indicated the resident stated he/she did not sleep at all the night before. The note revealed the long term care supervisor was not available to discuss the incident and the resident was concerned no one would believe him/her. At 6:30 PM, the note indicated the resident had spoke with the long term care supervisor, was ensured the incident was being

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F 225	Continued From page 9	F 225		

handled, and the resident felt a little more at ease.

On 8/5/14 at 1:20 PM, observation revealed the resident lying sideways on his/her bed listening to an audio book. Continued observation revealed the resident independently sat up and engaged in conversation with the surveyor. Observation revealed the resident became tearful, with his/her eyes bright red and filled with tears when he/she discussed the incident of being inappropriately touched by a staff member. The resident stated a male nurse aide had come into his/her room at 4:00 AM, sat down his/her water pitchure and had fondled the resident's chest, and stated "you know you like it". The resident continued to state he/she yelled for the nurse's aide to leave his/her room.

On 8/6/14 at 2:11 PM, observation revealed the resident independently ambulated into the hallway with his/her walker. Continued observation revealed when discussing the previous incident, the resident's eyes immediately turned red and flooded with tears. The resident became concerned he/she would be in trouble for reporting the incident and was frightful he/she would be shot with a gun by the accused staff.

On 8/5/14 at 11:00 AM, Administrative Nurse F stated he/she had been notified the resident had accused Nurse Aide C inappropriately touched him/her at 4:00 AM when his/her water was passed. Administrative Nurse F further verified Nurse Aide C continued to work the weekend after the resident had reported the incident to the staff and the staff had not notified the administrative staff over the weekend. Administrative Nurse F verified Nurse Aide C was

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F 225	Continued From page 10	F 225		

suspended on Monday 8/4/14, pending the outcome of the investigation. Administrative Nurse F further verified on Saturday 8/2/14 and Sunday 8/3/14 the staff had filled out incident reports and placed them in a locked box outside of the quality improvement officer's office. Administrative Nurse F further verified he/she was not aware of the incident until the quality improvement officer notified him/her mid-morning on Monday 8/5/14. Administrative Nurse F verified the only male aide who had worked with the resident was Nurse Aide C, the other employed male aide in the facility, is a friend of the resident and the male agency aide had worked a day shift.

On 8/5/14 at 1:35 PM, Nurse Aide B stated on Saturday 8/2/14, he/she visited with the resident. Nurse Aide B stated the resident had revealed to him/her, a few nights prior, a staff member had come into the resident's room around 4:00 AM, slammed his/her ice water down on the bedside table, and had fondled his/her chest. Nurse Aide B verified he/she had filled out an incident report on Saturday on 8/2/14.

On 8/5/14 at 2:25 PM, Administrative Nurse F verified he/she reviewed the facility's video surveillance and revealed Nurse Aide C was in the resident's room at 4:12 AM on 7/31/14 to deliver his/her water pitcher, the video surveillance revealed Nurse Aide C was in the resident's room for 1 minute and 1 second.

On 8/5/14 at 2:40 PM, Nurse E stated the resident notified him/her of the incident on Sunday 8/3/14, and the resident had reenacted the incident to describe what had happened. Nurse E verified the resident was tearful and

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frightened the accused staff member was going to work Sunday 8/3/14, night. Nurse E stated he/she informed a Medication Aide not to allow Nurse Aide C to work with the resident on Sunday night 8/3/14.

On 8/5/14 at 3:35 PM, Nurse Aide C verified he/she worked in the facility and provided care to the residents on Saturday 8/2/14 and Sunday 8/3/14.

On 8/5/14 a 4:16 PM, Nurse Aide D verified the resident had told him/her on Saturday 8/2/14, about the incident of a staff member touching him/her inappropriately. Nurse Aide D verified he/she filled out an incident report on Saturday 8/2/14 and Sunday 8/3/14. Nurse Aide D stated on Sunday 8/3/14, the resident told him/her the accused staff (Nurse Aide C) would work that evening and had broke down in tears and had stated he/she wanted the call light close and did not feel safe.

On 8/5/14 at 4:41 PM, Nurse Aide A stated on Sunday 8/3/14, the resident's call light went off, which was unusual due to the resident was independent with his/her activities of daily living, so the staff went to answer the call light quickly. Nurse Aide A revealed upon entering the resident's room he/she was found to be fearful and requested help to attach his/her call light so he/she could reach it in case the accused staff member (Nurse Aide C) came in his/her room, since Nurse Aide C was working that evening.

On 8/6/14 at 12:15 PM, Administrative Staff G verified Nurse Aide C had continued to work with other resident's in the facility after the resident had made the allegations of him/her being

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F 225	Continued From page 12 inappropriately touched for 2 days. Administrative Staff G further verified the staff had not notified his/her of the resident's accusations over the weekend and was not made aware until Monday 8/5/14. Administrative Staff G verified Nurse Aide C was not suspended until Monday 8/5/14, pending the outcome of the investigation. The facility's undated Abuse, Neglect and Exploitation policy indicated all facility employees, family members and volunteers are educated that all alleged or suspected violations involving mistreatment, neglect or abuse are reported immediately to the Administrator. The policy continued to indicate any alleged perpetrator of abuse, neglect, or exploitation, will be immediately suspended from employment and will leave the employment property and not return to the property until the investigation by the facility and law enforcement is complete and the incident is resolved. The facility failed to adequately investigate Resident #1's allegations of abuse, and protect all residents during the investigation. This failure placed all residents in immediate jeopardy. The immediate jeopardy was abated on 8/11/14, when the facility completed inserving on all nursing staff on how to report and immediately notify administrative staff regarding allegation of abuse and residents feeling safe until a thorough investigation has been completed by the facility. The deficient practice remains at a scope and severity of an F.	F 225		
F 250	483.15(g)(1) PROVISION OF MEDICALLY	F 250		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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RELATED SOCIAL SERVICE

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 30 residents. The sample included 3 residents. Based on observation, interview, and record review the facility failed to provide pychosocial services to Resident #1 after allegations of abuse were reported and the resident remained tearful and frightened.

Findings included:

- Resident #1's signed physician orders, dated 8/1/14, revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion), worsening expressive aphasia (condition with disordered or absent language function), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), macular degeneration (progressive deterioration of the retina), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The quarterly (MDS) Minimum Data set 3.0 assessment, dated 7/29/14, indicated the resident had intact cognition with a (BIMS) Brief Interview

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	17E015	A. BUILDING _____ B. WING _____	C 08/13/2014

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for Mental Status score of 13 without any behaviors exhibited, and had impaired vision with use of corrective lenses. The MDS further indicated the resident was independent with all of his/her activities of daily living and had received antianxiety, antidepressant, and diuretic medications.

The 5/15/14 care plan instructed the staff to visit with the resident during personal cares, to assist the resident to find words when needed, and to assist the resident with decision making as needed.

The 7/15/14 physician's progress note indicated the resident wanted to go home, but the resident was not capable to care for him/herself any longer.

The 8/3/14 at 5:00 PM nurse's note revealed the resident was visibly upset regarding the incident, which the resident had reported he/she was inappropriately touched by staff, that had happened a few nights ago. The note indicated the staff explained to the resident things would be okay and the incident would be discussed with the long term care supervisor on Monday.

Review of the July/August 2014 nursing schedule revealed Nurse Aide C worked the following shifts:
- 7/30/14 6:00 PM to 6:00 AM
- 8/2/14 2:00 PM to 10:00 PM
- 8/3/14 6:00 PM to 6:00 AM

The 8/4/14 at 8:00 AM nurse's note indicated the resident continued to be upset regarding the incident. The note indicated the resident stated he/she did not sleep at all the night before. The

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note revealed the long term care supervisor was not available to discuss the incident and the resident was concerned no one would believe him/her. At 6:30 PM, the note indicated the resident had spoke with the long term care supervisor, was ensured the incident was being handled, and the resident felt a little more at ease.

Review of the medical record did not reveal any documentation the facility staff had attended to the psychosocial needs of the resident.

On 8/5/14 at 1:20 PM, observation revealed the resident lying sideways on his/her bed listening to an audio book. Continued observation revealed the resident independently sat up and engaged in conversation with the surveyor. Observation revealed the resident became tearful, with his/her eyes bright red and filled with tears when he/she discussed the incident of being inappropriately touched by a staff member. The resident stated a male nurse aide had come into his/her room at 4:00 AM, sat down his/her water pitchure and had fondled the resident's chest, and stated "you know you like it". The resident continued to state he/she yelled for the nurse's aide to leave his/her room.

On 8/6/14 at 2:11 PM, observation revealed the resident independently ambulated into the hallway with his/her walker. Continued observation revealed when discussing the previous incident, the resident's eyes immediately turned red and flooded with tears. The resident became concerned he/she would be in trouble for reporting the incident and was frightful he/she would be shot with a gun by the accused staff.

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On 8/5/14 at 11:00 AM, Administrative Nurse F stated he/she had been notified the resident had accused Nurse Aide C inappropriately touched him/her at 4:00 AM when his/her water was passed. Administrative Nurse F further verified Nurse Aide C continued to work the weekend after the resident had reported the incident to the staff and the staff had not notified the administrative staff over the weekend. Administrative Nurse F verified Nurse Aide C was suspended on Monday 8/4/14, pending the outcome of the investigation. Administrative Nurse F further verified on Saturday 8/2/14 and Sunday 8/3/14 the staff had filled out incident reports and placed them in a locked box outside of the quality improvement officer's office. Administrative Nurse F further verified he/she was not aware of the incident until the quality improvement officer notified him/her mid-morning on Monday 8/5/14. Administrative Nurse F verified the only male aide who had worked with the resident was Nurse Aide C, the other employed male aide in the facility, is a friend of the resident and the male agency aide had worked a day shift.

On 8/5/14 at 1:35 PM, Nurse Aide B stated on Saturday 8/2/14, he/she visited with the resident. Nurse Aide B stated the resident had revealed to him/her, a few nights prior, a staff member had come into the resident's room around 4:00 AM, slammed his/her ice water down on the bedside table, and had fondled his/her chest. Nurse Aide B verified he/she had filled out an incident report on Saturday on 8/2/14.

On 8/5/14 at 2:25 PM, Administrative Nurse F verified he/she reviewed the facility's video surveillance and revealed Nurse Aide C was in

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the resident's room at 4:12 AM on 7/31/14 to deliver his/her water pitcher, the video surveillance revealed Nurse Aide C was in the resident's room for 1 minute and 1 second.

On 8/5/14 at 2:40 PM, Nurse E stated the resident notified him/her of the incident on Sunday 8/3/14, and the resident had reenacted the incident to describe what had happened. Nurse E verified the resident was tearful and frightened the accused staff member was going to work Sunday 8/3/14, night. Nurse E stated he/she informed a Medication Aide not to allow Nurse Aide C to work with the resident on Sunday night, 8/3/14.

On 8/5/14 at 3:35 PM, Nurse Aide C verified he/she worked in the facility and provided care to the residents on Saturday 8/2/14 and Sunday 8/3/14.

On 8/5/14 a 4:16 PM, Nurse Aide D verified the resident had told him/her on Saturday 8/2/14, about the incident of a staff member touching him/her inappropriately. Nurse Aide D verified he/she filled out an incident report on Saturday 8/2/14 and Sunday 8/3/14. Nurse Aide D stated on Sunday 8/3/14, the resident told him/her the accused staff (Nurse Aide C) would work that evening and had broke down in tears and had stated he/she wanted the call light close and did not feel safe.

On 8/5/14 at 4:41 PM, Nurse Aide A stated on Sunday 8/3/14, the resident's call light went off, which was unusual due to the resident was independent with his/her activities of daily living, so the staff went to answer the call light quickly. Nurse Aide A revealed upon entering the

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resident's room he/she was found to be fearful and requested help to attach his/her call light so he/she could reach it in case the accused staff member (Nurse Aide C) came in his/her room, since Nurse Aide C was working that evening.

On 8/6/14 at 12:15 PM, Administrative Staff G verified Nurse Aide C had continued to work with other resident's in the facility after the resident had made the allegations of him/her being inappropriately touched for 2 days. Administrative Staff G further verified the staff had not notified his/her of the resident's accusations over the weekend and was not made aware until Monday 8/5/14. Administrative Staff G verified Nurse Aide C was not suspended until Monday 8/5/14, pending the outcome of the investigation.

On 8/6/14 at 12:15 PM, Administrative Nurse F verified the facility's social service designee was on vacation on the only psychosocial care the resident had was from his/her child, visiting with the nursing staff, and visiting with Admibistrative Nurse F. Administrative Nurse F verified the resident appeared clearly upset and fearful and the facility staff had not documented any psychosocial envolvement with the resident.

The facility failed to provide Resident #1 with psychosocial services after allegation of abuse by the staff.